

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-3364.M5

MDR Tracking Number: M5-04-3521-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on June 14, 2004. According to the TWCC Rule 133.308 (d)(1) dates of service 3/3/03 through 6/11/03 are considered untimely and not eligible for review.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, therapeutic exercises, neuromuscular re-education, gait training, hot/cold packs, ultrasound, myofascial release, joint mobilization, non-invasive ear or pulse oximetry for oxygen saturation, and mechanical traction rendered on 6/17/03 through 8/22/03 were not found to be medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On September 17, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	MAR	Paid	EOB Denial Code	Rationale
7/21/03	99080	\$15.00	\$15.00	\$0.00	U	Review of the carrier's EOB revealed the carrier denied CPT code 99080-73 as "U-Unnecessary Medical without a Peer Review." The TWCC-73 is a required report and is not subject to an IRO review. Review of the TWCC-73 report supports delivery of service. Reimbursement is recommended in the amount of \$15.00.
8/4/03	99211	\$20.00	\$18.69 x 125% = \$23.37	\$0.00	F, T9	Review of the carrier's explanation of benefits revealed the carrier denied CPT code 99211 as "T9-Reduced to estimated usual and customary charge, based on available research, data, Labor Code Sec 413.043, and 202 Pharmacy Fee Guideline, 28 Tex: Admin. Code 134.503. The Pharmacy Fee Guideline is not applicable to an Evaluation and Management code. According to the Medicare Fee Schedule the MAR amount for CPT code 99211 is \$23.37. According to the TWCC Rule 134.202 (d) "In all

						cases, reimbursement shall be the least of the: MAR amount as established by this rule; health care provider's usual and customary charge;" Therefore the requestor is entitled to reimbursement in the amount of \$20.00.
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ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule

133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 7/21/03 through 8/4/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issues this 8th day of October 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

NOTICE OF INDEPENDENT REVIEW DECISION

September 14, 2004

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-3521-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 41 year-old male injured his low back on ____ while he was using a weed eater as a grounds keeper. He has been treated with medications and therapy.

Requested Service(s)

Levels I, II, and III office visits, therapeutic exercises, neuromuscular reeducation, gait training, hot/cold pack therapy, ultrasound, myofascial release, joint mobilization, noninvasive ear or pulse oximetry for oxygen saturation, and mechanical traction for dates of service 06/17/03 through 08/22/03

Decision

It is determined that the office visits, therapeutic exercises, neuromuscular reeducation, gait training, hot/cold pack therapy, ultrasound, myofascial release, joint mobilization, noninvasive ear or pulse oximetry for oxygen saturation, and mechanical traction for dates of service 06/17/03 through 08/22/03 were not medically necessary to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation does not indicate the necessity for the services in question. A functional capacity evaluation was done on 06/05/03 with a recommendation for possible return to work however therapy was continued. The patient has received extensive physical medicine management without an established efficacy for the continued application of these passive therapeutic treatments. Therefore, the office visits, therapeutic exercises, neuromuscular reeducation, gait training, hot/cold pack therapy, ultrasound, myofascial release, joint mobilization, noninvasive ear or pulse oximetry for oxygen saturation, and mechanical traction were not medically necessary to treat this patient's medical condition.

Sincerely,